STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
701012701	or contraction.	IDENTIFICATION NOMBER.	A. BUILDING: _			
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	RK 8810 COL INDIANAI	BY BLVD POLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS	}	R 000			
	This visit was for an I Survey. This visit inc Complaint IN0014514	luded the investigation of				
	deficiencies related to	49 - Substantiated - State o the allegations are cited at 8, R0154, R0187, R273,				
	Survey Dates: February 27 & 28, 20	14 and March 6, 2014				
	Facility number: 013 Provider number: 013 AIM number: NA					
	Survey Team: Mary Jane G. Fischer	r RN				
	Census bed type: Residential: 4 Total: 4					
	Census payor type: Other: 4 Total: 4					
	Sample: 5					
	These State findings 410 IAC 16.2-5.	are cited in accordance with				
	Quality Review was on RN on March 12, 201	completed by Tammy Alley 4.				
R 006	410 IAC 16.2-5-0.5(f) Care - Deficiency	(1-5) Scope of Residential	R 006			4/5/14
	(f) The resident must	be discharged if the				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or dortheorion	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		013034	B. WING		C 03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	2K	BY BLVD			
			POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
R 006	nursing oversight; (3) requires less than day comprehensive in nursing oversight, or has not entered into a appropriately licensed choice to provide thos (4) is not medically st (5) meets at least two (3) criteria unless the and the health facility needs: (A) Requires total ass (B) Requires total ass (C) Requires total	resident or others; our (24) hour per day and care or comprehensive twenty-four (24) hour per dursing care, comprehensive rehabilitative therapies and a contract with an diprovider of the resident 's see services; able; or of (2) of the following three resident is medically stable can meet the resident 's sistance with eating. Sistance with toileting. Sistance with transferring.  It as evidenced by:  In, record review and alled to discharge a resident, and displayed aggressive and as which endangered others, avide a discharge for 1 of 5 Resident "A").  The transferring and the record review.  The transferring and the resident and the record review.  The transferring and the resident and the record review.	R 006			
		l at a secured dementia unit				

Indiana State Department of Health

STATE FORM 6899 GYZ711 If continuation sheet 2 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
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		8810 CO	LBY BLVD	, ZIP CODE		
MORNING	SSIDE OF COLLEGE PAR	K	POLIS, IN 46268			
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R 006	Continued From page	2	R 006			
	at 12:15 p.m., noted the Resident "A."  "02-11-14 3:00 to 11:00 most of shift. 02-19-10 nervous and scared. room. 02-21-14 7:00 episode of aggression 30 minute checks - ca 3:00 p.m., aggressive 3:00 p.m., to 11:00 p.  A review of the Nursing Resident Technology.	Thinks people are in his a.m., to 3:00 p.m., had a. 3:00 p.m., to 11:00 p.m., alm. 02-22-14 7:00 a.m., to be behavior during the day.				
	care. Would not allow nurses aide] to assist					
	with me about 'getting shaking more while h 'afraid' of 'hurting with times before in his life respected his anger a	ind I left room after stating d aides here would verbally				
	walker in the dining roup from his walker. The next to the resident at	m. "Res. [resident] sat in his com and had refused to get this writer and the CNA set the table to keep res. safe valker. Res. stood up and				

Indiana State Department of Health

STATE FORM 6899 GYZ711 If continuation sheet 3 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		013034	B. WING		C 03/06/2014	
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WORNING	SIDE OF COLLEGE PAR	INDIANA	POLIS, IN 46268			
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R 006	Continued From page	3	R 006			
	into everything on this his walker into this wr [Director of Nurses] was to the unit. Res. was was also running his and DON attempted to Res. came out still att [Medical Doctor] notification. POA [powerefused to have the resthan the [name of hos him sent out at this tirthe phone and was all sitting in TV room call noted. Res. apologiz sorry if I offended any notified and stated the	ied and ordered to send ychiatric] hospital for wer of attorney] notified and es. sent out anywhere other spital], but does not want me. POA spoke to res. over ole to calm res. down. Res. m. No further agitation ed to writer and stated, 'I am one.' MD notified. POA at next time if this res. d attacks staff, to send res.				
	breakfast. Attempted walker. Jabbed fork is several times. Becan [Family member] mad DON."  "02-22-14 at 8:25 p.m at 1400 [2:00 p.m.]. It 1440 [2:40 p.m.]. Stathow his day going <s 'tomorrow,="" coming="" enough,'="" holding="" i="" in="" member].="" phone,="" regards="" remember]="" res.="" sitting="" talk.="" td="" to="" to<="" tom="" tomorrow,="" wanted="" when=""><td>ninded res. [name of family orrow, res. replied, ' Asked resident if he did state 'I'm, I'm not clear</td><td></td><td></td><td></td><td></td></s>	ninded res. [name of family orrow, res. replied, ' Asked resident if he did state 'I'm, I'm not clear				

Indiana State Department of Health

STATE FORM 6899 GYZ711 If continuation sheet 4 of 37

Indiana S	tate Department of He	alth			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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MORRING	ODE OF GOLLLOC PAR	INDIANA	POLIS, IN 46268	3	
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				DEFICIENCY)	
R 006	Continued From page	e 4	R 006		
	talking to res., paged attempted to remove one minute] she remove res. hands. DON to genedication], page <si [name="" administered="" again="" ativan<="" being="" box="" buried="" cords,="" encouraging="" family="" he="" hit="" incomple="" members]="" of="" point.'="" res.="" searabling="" si="" stating="" td="" the="" to="" tv="" walking="" which=""><td>belt. DON quickly [under oved belt while restraining get Ativan [an anti-anxiety c&gt; MD and request 9-1-1. It is sentences talking about per], about res. older today states, 'there's no steady around room, een shower hose, then TV inst his head. Verbally it down, let us help. DON</td><td></td><td></td><td></td></si>	belt. DON quickly [under oved belt while restraining get Ativan [an anti-anxiety c> MD and request 9-1-1. It is sentences talking about per], about res. older today states, 'there's no steady around room, een shower hose, then TV inst his head. Verbally it down, let us help. DON			
	name] held by myself hands [which had TV loosely]. I led him to mirror, cords, heavy o	. Held [name of resident] input cords around them hallway to get away from objects in room. Ambulance ported to [name of hospital]."			
	"02-22-14 at 10:40 p.i reddened at proximal location noted after be	tip [towards head] of belt			
	at 7:30 p.m., Call plac Administrator] to notif had went out to ER [e events leading up to t Executive Director wa well voice mails were	y him [name of resident] mergency room] and the his transfer. Also the as notified at this time as left with both parties."			
	from [name of admini- [name of resident] col	at 6:28 p.m Return call strator] he was informed of ndition and transfer to ER." n 02-27-14 at 11:00 a.m.,			
	_	Care indicated that on the			

day of the events on 02-21-14, the resident

STATE FORM 6899 If continuation sheet 5 of 37 GYZ711

PRINTED: 04/17/2014 FORM APPROVED

Indiana S	State Department of He	ealth			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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		INDIANA	POLIS, IN 4626	8	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
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R 006	Continued From page	e 5	R 006		
		to staff in alcoding a large of			
		nto staff, including herself.			
	The Director indicated				
	_	surgery when the resident			
		r. The Director further			
		t was picking up the walker			
		kick at staff and took the			
		it into the pillars" of the			
	dementia unit. During				
	02-28-14 at 11:00 a.n	n., the "pillars" on the			
	dementia unit were o	bserved. Licensed Nurse #4			
	pointed out the areas	where the resident			
	"rammed" the walker.	. On one pillar was an area			
	indented in approxima	ately 1 inch by 2 inches and			
	a metal corner protec	ctor was visible. The area			
	lacked a painted surfa	ace. Adjacent to this pillar			
	was another area, as	identified by the nurse,			
	where the resident ra	mmed the walker. This area			
	measured 1 inch by 1	I inch. The Director further			
		ed a telephone call on a			
		sday" prior to the incident on			
	_	ght shift nurse. "She told me			
		o know that she recognized			
		"] from his previous facility			
	=	atened the staff with a knife."			
	During an interview o	n 02-27-14 at 12:45 p.m.,			
		dicated she had recognized			
	the resident from the				
		name of the Director of			
		ne nurse went on to indicate			
	_	revious facility, her aide			
		me of resident "A"] and he			
	<u>-</u>	A tried to back away - and it			
		army knife. "We ran down			
		out swinging with it - he was			
		f his room, heavy things that			
		police department had to be			
	called."				
	During interview on 0	2-28-14 at 1:00 p.m., the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	E, ZIP CODE		
MORNING	SSIDE OF COLLEGE PAR	2K	LBY BLVD			
			POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 006	Continued From page	e 6	R 006			
	the resident kept bane everything. "On the was holding onto the was talking to [name The family wouldn't le hospital that the doctowas on Friday - he to I heard [name of Resof her room and I told there so she wouldn't the incident with the bulling at all kinds of he even tried to pull of shower. It wasn't until the wasn't until	ging his walker into video you can actually see valker with one hand and I of physician] on the phone. It us send him out to the or wanted him to go to, that are up the entire dining room. It is the CNA to get her back in get hurt. On Saturday was belt. That night he was cords, TV, just everything, on the had held set in the il 911 got here that we could is hands and around his				
	policy on 02-27-14 at following: "It is Morningside of C in writing by certified requested, in advance or discharge from the discharge are the folled. The safety of indivendangered; 4. The health of indivotherwise be endange." The notice will be predays in advance of the discharge, unless and 3. An emergency arise health of individuals in otherwise be endange.  During an interview of the safety of the saf	e of any proposed transfer Facility. Reasons for owing: riduals in the Facility is riduals in the Facility would ered."  ovided at least thirty (30) e proposed transfer or y of the following applies: ses in which the safety or n the Facility would				

Indiana State Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BLULDING:		COM	IPLETED
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OR SUPPLIER			, ZIP CODE		
COLLEGE PAR	K				
SUMMARY STA			PROVIDER'S PLAN OF CO	RRECTION	(X5)
EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	COMPLETE DATE
ued From page	7	R 006			
t had not been	given a discharge notice.				
-	tes to Complaint				
		R 090			4/5/14
ement of the fannistrator shall following: rming the division of a rence that direct or health of a rence may be maitten report, or dor sent by element outbreak onings; s; or ior accidents. In the emergence of the emergence of the emergence of medical, of other health caresident or resident of an indivision of	cility. The responsibilities of include, but are not limited for within twenty-four (24) are of an unusual ly threatens the welfare, esident. Notice of unusual ade by telephone, followed by a written report only that ctronic mail to the division (24) hour time period. include, but are not limited as;				
E TO THE COMPANY OF THE CONSTITUTE OF THE CONSTI	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  ued From page at had not been tate finding rela 15149.  C 16.2-5-1.3(g) ement - Deficie e administrator in ement of the fa ministrator shall following: orming the division of becoming awe ence that direct or health of a re ence may be miritten report, or d or sent by ele the twenty-four all occurrences demic outbreak conings; s; or jor accidents. ivision cannot be to the emergence and by the division of the emergence that direct or the division cannot be to the emergence that direct or other health car enced by the division of medical, cor or of medical, cor or of medical, cor or of medical or containing director sion of an indivision of age to an adult	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ued From page 7  In thad not been given a discharge notice.  Itate finding relates to Complaint 15149.  C 16.2-5-1.3(g)(1-6) Administration and mement - Deficiency  administrator is responsible for the overall mement of the facility. The responsibilities of ministrator shall include, but are not limited following:  In the division within twenty-four (24) of becoming aware of an unusual mence that directly threatens the welfare, or health of a resident. Notice of unusual mence may be made by telephone, followed mitten report, or by a written report only that do r sent by electronic mail to the division the twenty-four (24) hour time period.  all occurrences include, but are not limited demic outbreaks;  sonings;  s; or	COLLEGE PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Late finding relates to Complaint 15149.  C 16.2-5-1.3(g)(1-6) Administration and ement - Deficiency  e administrator is responsible for the overall ement of the facility. The responsibilities of ministrator shall include, but are not limited following:  corner hat this directly threatens the welfare, or health of a resident. Notice of unusual ence that directly threatens the welfare, or health of a resident. Notice of unusual ence may be made by telephone, followed ritten report, or by a written report only that do r sent by electronic mail to the division the twenty-four (24) hour time period.  all occurrences include, but are not limited demic outbreaks; sonings; s; or jor accidents.  ivision cannot be reached, a call shall be to the emergency telephone number led by the division.  mptly arranging for or assisting with the on of medical, dental, podiatry, or nursing rother health care services as requested resident or resident's legal representative. Italianing director approval prior to the ision of an individual under eighteen (18) of age to an adult facility.	STREET ADDRESS, CITY, STATE, ZIP CODE  8810 COLSY BLVD INDIANAPOLIS, IN 46268  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFY INFORMATION)  REGULATORY OR LSC IDENTIFY INFORMATION  REGULATORY OR LSC IDENTIFY INFORMATION  REGULATORY OR LSC IDENTIFY INFORMATION)  REGULATORY OR LSC IDENTIFY INFORMATION  REGULATORY OR LSC INFORMATION  REGULATORY OR LSC INFORMATION  REGULATORY OR RESCULT  REGULATORY OR RESCULT  REGULATORY OR RESCULT	DR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  8810 COLEY BLVD INDIANAPOLIS, IN 46268  SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCY MUST BE PRECEDED BY PULL RECULATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER'S PLAN OF CORRECTION RECULATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER'S PLAN OF CORRECTION RECULATORY OR LSC IDENTIFYING INFORMATION)  REACH From page 7  In had not been given a discharge notice.  State finding relates to Complaint 15149.  C 16.2-5-1.3(g)(1-6) Administration and ement - Deficiency  Be administrator is responsible for the overall ement of the facility. The responsibilities of ministrator shall include, but are not limited following:  The provider of the facility of the coming aware of an unusual ence that directly threatens the welfare, or health of a resident. Notice of unusual ence may be made by telephone, followed ritten report, or by a written report only that do r sent by electronic mail to the division the twenty-four (24) hour time period.  all occurrences include, but are not limited demic outbreaks; sonings;  s; or jor accidents, significant of the control of the division of the twenty-four (24) hour time period.  all occurrences include, but are not limited demic outbreaks; sonings;  s; or jor accidents, included the providence of the division of the twenty-four (24) hour time period.  all occurrences include, but are not limited demic outbreaks; sonings;  s; or jor accidents.  Significant is responsibilities of ministrator is responsible for the control of medical, dental, podiatry, or nursing other health care services as requested resident or resident's legal representative, along director approval prior to the cinc of an individual under eighteen (18) of age to an adult facility.

Indiana State Department of Health

STATE FORM 6899 GYZ711 If continuation sheet 8 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE			
MORNINGSIDE OF COLLEGE PAR	!K	NLBY BLVD APOLIS, IN 46268				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
twelve (12) months. (5) Posting the results survey of the facility of surveyors, any plan of respect to the facility, surveys. The results is examination in the factor accessible to resident their availability. (6) Maintaining report the division in each factor and making the	sof the most recent annual conducted by state of correction in effect with and any subsequent must be available for cility in a place readily and a notice posted of sof surveys conducted by acility for a period of two (2)	R 090				
This RULE is not met as evidenced by: Based on record review and interview the facility failed to inform the Indiana State Department of Health of an unusual occurrence, in that when a resident displayed aggressive and threatening behaviors, and was found with a belt around his neck which resulted in a reddened area, the Administrator did not report the occurrence for 1 of 5 sampled residents who displayed aggressive and threatening behaviors to others and eventually himself. (Resident "A").  Findings include:  The record for Resident "A" was reviewed on 02-27-14 at 10:15 a.m. Diagnoses included, but were not limited to, Lewy Body dementia and						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		С
		013034	B. WING		03/06/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	SIDE OF COLLEGE PAR	8810 COLE	BY BLVD		
		INDIANAPO	OLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
R 090	Continued From page	9	R 090		
		nitted to the facility on lat a secured dementia unit to the facility.			
	following related to R "02-22-14 7:00 a.m.,	ur Report book noted the esident "A." to 3:00 p.m., Aggressive ay. 3:00 p.m., to 11:00 p.m.,			
	the following: "02-15-14 at 1925 [7: with me about 'getting shaking more while h 'afraid' of 'hurting with times before in his life respected his anger a	and I left room after stating d aides here would verbally			
	walker in the dining roup from his walker. The next to the resident at from falling from his want into everything on this his walker into this walker into the walker into this walker into the walker.	m. "Res. [resident] sat in his from and had refused to get his writer and the CNA set to the table to keep res. safe valker. Res. stood up and the table. Res. ran his walker is unit. He was also running riter and the CNA. The DON was notified and had arrived as still extremely agitated and walker into the DON. Writer to take res. into his room.			
	at 1400 [2:00 p.m.]. I	n. Resident up ambulating n DR [dining room] until ited 'it's terrible' when asked			

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Indiana S	tate Department of He	alth			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		042024	B. WING		C
		013034			03/06/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		8810 CO	LBY BLVD		
MORNING	SIDE OF COLLEGE PAR	K	POLIS, IN 46268	3	
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TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
R 090	Continued From page	10	R 090		
11 000	Continued From page	: 10	1 1 000		
	how his day going <s< td=""><td>ic&gt;. 1500 [3:00 p.m.] in DR</td><td></td><td></td><td></td></s<>	ic>. 1500 [3:00 p.m.] in DR			
	sitting holding phone,	talking about [family			
	member]. When I rer	ninded res. [name of family			
	member] coming tom	orrow, res. replied,			
	'tomorrow, tomorrow,				
	wanted to talk. Res.	did state 'I'm, I'm not clear			
	enough,' in regards to	talking. 6:40 p.m.			
		saw his eyes open, and his			
		neck medium tight. Began			
	talking to res., paged				
		belt. DON quickly [under			
	-	oved belt while restraining			
	=	get Ativan [an anti-anxiety			
	-	c> MD and request 9-1-1.			
		te sentences talking about			
	[name of family meml				
	-	today states, 'there's no			
	point.' Res. walking s				
		en shower hose, then TV			
		nst his head. Verbally			
	•				
		t down, let us help. DON			
	administered Ativan				
		deltoid while [resident's . Held [name of resident]			
		input cords around them			
		hallway to get away from			
		objects in room. Ambulance			
	crew present transp	orted to [name of hospital]."			
	"02-22-14 at 10:40 p.	m Res neck faintly			
	•	tip [towards head] of belt			
	location noted after be				
	iocation noted after be	Sit ICIIIOVEU.			
	"[] ate entry] 02-23-14	at 6:25 p.m On 02-22-14			
	at 7:30 p.m. Call plac				
	· · · · · · · · · · · · · · · · · · ·	y him [name of resident]			
	=	emergency room] and the			
	events leading up to t				
	Executive Director wa	s notified at this time as			

well voice mails were left with both parties."

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING		С
		013034	B. WING		03/06/2014
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE	
MORNING	SSIDE OF COLLEGE PAR	8810 COLE	BY BLVD OLIS, IN 46268	3	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
R 090	Continued From page	e 11	R 090		
	from [name of admini [name of resident] co  During an interview o the Director of Health she received a teleph or Thursday" prior to from the night shift nu wanted me to know th Resident "A"] from his had threatened the st				
	Licensed Nurse #6 in the resident from the "concerned." "I told [I Health Services]." The that one day, at the pwent to check on [nar had a knife. The CN/looked like maybe and the hall and he came throwing things out of	n 02-27-14 at 12:45 p.m., dicated she had recognized prior facility and was name of the Director of ne nurse went on to indicate revious facility, her aide me of resident "A"] and he A tried to back away - and it army knife. "We ran down out swinging with it - he was f his room, heavy things that police department had to be			
	Director of Health Set the resident kept ban- everything. On the vi holding onto the walk talking to [name of ph family wouldn't let us that the doctor wante Friday - he tore up the [name of Resident "D room and I told the C	2-28-14 at 1:00 p.m., the rvices indicated on 02-21-14 ging his walker into ideo you can actually see me er with one hand and I was aysician] on the phone. The send him out to the hospital d him to go to, that was on e entire dining room. I heard "] start to come out of her NA to get her back in there part. On Saturday was the			

Indiana State Department of Health

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMIT LETED		
		013034	B. WING		03/0	)6/2014	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
MORNING	SIDE OF COLLEGE PAR	8810 COL	BY BLVD OLIS, IN 46268	3			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE	
R 090	Continued From page	e 12	R 090				
	incident with the belt. all kinds of cords, TV tried to pull on the harwasn't until 911 got he cords out of his hands. A review of the Facilita a.m., titled "State Rep Occurrences," and daindicated the following "Policy: The facility s violations involving mabuse, including injur misappropriation of reimmediately to the add to other officials in ac The administrator is reinforming the Indiana Division of Long Term followed by written no hours, of unusual occurrences, or unusual occurrences or major accidence During an interview of the Administrator indianal division of the Administrator indianal control of the Administrator indianal	That night he was pulling at just everything, he even d held set in the shower. It ere that we could get the s and around his wrists."  by policy on 02-28-14 at 9:30 portable Unusual ated as revised 02-2013, gg:  hall ensure that all alleged istreatment, neglect, or ies of unknown source and esident property are reported liministrator of the facility and cordance with State law. esponsible for immediately State Department of Health, in Care by telephone, office within twenty-four currence that directly safety, or health of the sic>, including, but not nic outbreaks, poisonings, ints."  In 02-27-14 at 11:00 a.m., cated he made the decision ent to the Indiana State					
	This State finding relations 1N00145149.	ates to Complaint					
R 148	410 IAC 16.2-5-1.5(e Standards - Deficience	)(1-4) Sanitation and Safety cy	R 148			4/5/14	
	(e) The facility shall m	naintain buildings, grounds,					

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STATE FORM 6899 GYZ711 If continuation sheet 13 of 37

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  810 COLEY BLVD  NIDIANAPOLIS, IN 4258  (X4) ID  REFEIX TAG  CROSS-REFERENCE TO THE APPROPRIATE TAG  CROSS-REFERENCE TO THE APPROPRIATE TAG  CONTINUED TO THE APPROPRIATE		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  8810 COLBY BLVD  (NA) ID  PREFIX TAG  COntinued From page 13  and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:  (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.  (2) The electrical system, including appliances, cords, switches, alternate powers sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.  (3) All plumbing shall function properly and comply with state plumbing codes.  (4) At least yearly, heating and ventilating systems shall be inspected.  This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the security of residents, in that when residents had physician orders to reside in a secured unit, the facility failed to ensure the entrance door to the dementia unit remained secure and the nursing staff failed to answer the alect that the entrance door was unsecured for 1 of 1 dementia units observed. This deficient practice had the potential to affect 4 of 4 residents residing on the secured unit. (Resident B, C, D and E.)  Findings include:							;
MORNINGSIDE OF COLLEGE PARK   INDIANAPOLIS, IN 46268			013034	B. WING		03/0	6/2014
(XA)  D   SUMMARY STATEMENT OF DEFICIENCIES   PRECED BY FULL   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PRECED BY FULL   PREFIX TAG   PRECEDITORY OR LSC IDENTIFYING INFORMATION)	NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE		
R 148  Continued From page 13  and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:  (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.  (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and comply with state electrical codes.  (3) All plumbing shall function properly and comply with state plumbing codes.  (4) At least yearly, heating and ventilating systems shall be inspected.  This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the security of residents, in that when residents had physician orders to reside in a secured unit, the facility failed to ensure the entrance door was unsecured for 1 of 1 dementia units observed. This deficient practice had the potential to affect 4 of 4 residents residing on the secured unit. (Resident B, C, D and E.)  Findings include:	MORNING	SIDE OF COLLEGE PAR	2K		3		
and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:  (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.  (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.  (3) All plumbing shall function properly and comply with state plumbing codes.  (4) At least yearly, heating and ventilating systems shall be inspected.  This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the security of residents, in that when residents had physician orders to reside in a secured unit, the facility failed to ensure the entrance door to the dementia unit remained secure and the nursing staff failed to answer the alert that the entrance door was unsecured for 1 of 1 dementia units observed. This deficient practice had the potential to affect 4 of 4 residents residing on the secured unit. (Resident B, C, D and E.)  Findings include:	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
Dietary Supervisor escorted this surveyor to the secured dementia unit. The Dietary Supervisor entered the code into the key pad to gain entrance to the unit.  During this observation 4 resident's resided on	R 148	and equipment in a clarepair, and free of hat affect the health and the public as follows:  (1) Each facility shall written program for montinued upkeep of the cords, switches, alternal arm and detection stonguarantee safe fund with state electrical cords.  (3) All plumbing shall comply with state plund (4) At least yearly, he systems shall be inspected in the cords of the cords	lean condition, in good zards that may adversely welfare of the residents or establish and implement a laintenance to ensure the the facility. It is including appliances, mate power sources, fire systems, shall be maintained ctioning and compliance odes. If function properly and mbing codes. If a sevidenced by:  It as evidenced by:  It is evid	R 148			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		013034	B. WING			C <b>06/2014</b>
NAME OF PROVI	DER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, ,	
MORNINGSIDE	E OF COLLEGE PAR	K 8810 COL INDIANAP	BY BLVD OLIS, IN 46268	3		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
this Remoores dia der ren At t phy pla Remoorec wh Alz dia rec res "ren Remo rec wh and cur tim ord sec Remo rec wh Alz dia rec wh and cur tim ord sec Remo rec wh Alz dia rec	esident "B" was assoved to the secured sident's record indicate and debility mained current at the time of admissing ysician orders which acement of secured esident "C" was assoved to the unit on the cord indicated the resident had physician agnoses remained cord review. At the sident had physician equired placement of esident "D" was assoved to the unit on the esident had physician equired placement of esident "D" was assoved to the unit on the esident had physician equired placement of esident "D" was assoved to the unit on the esident that the time of the esident "E" was assoved to the unit on the esident "E" was ass	essed on 12-17-13 and unit on 01-31-14. The cated the resident had ided, but were not limited to, These diagnoses he time of the record review. On the resident had in the reflected "required unit for safety."  essed on 02-20-14 and 02-22-14. The resident's esident had diagnoses here not limited to, and falls with injury. These current at the time of the time of admission the norders which reflected of secured unit for safety."  essed on 01-27-14 and 01-29-14. The resident's esident had diagnoses here not limited to, dementia see diagnoses remained the record review. At the resident had physician differential required placement of y."  essed on 02-24-14 and 02-26-14. The resident's esident had diagnoses	R 148			

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
	013034		B. WING		03/0	6/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	8810 COLI				
			OLIS, IN 46268			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
R 148	Continued From page	e 15	R 148			
	"required placement	of secured unit for safety."				
	Resident "E" was obsidown the hallway, an Additional observatio and again at 12:30 p. pace around the unit. waiting for his ride as night. During intervielicensed nurse #4 indup all night, pacing be staff tried to engage to activities, however the	n on 02-28-14 at 8:30 a.m., served pacing back and forth d going to the secured door. In son 02-28-14 at 9:00 a.m., Im., the resident continued to The resident stated he was to he had been working all the won 02-28-14 at 9:00 a.m., licated the resident had been the ack and forth. The nursing the resident in various e resident would stand up n, and walk to the entrance				
	During an observation on 02-28-14 at 12:35 p.m., the residents were ambulating to the dining room for the noon meal service.  Observation on 02-28-14 at 12:50 p.m., the door to the secured unit was open and the entrance was unattended.					
	the receptionist close was unsure of how lo opened or who opene	n on 02-28-14 at 12:52 p.m., d the door and indicated she ing the door had been ed it. She further indicated back too hard it won't				
		h Services was notified of the secured dementia unit.				
	Director of Health Se	nd the "Chef" pushed the				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		013034	B. WING		03/06	/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	RK 8810 COL	BY BLVD POLIS, IN 46268	3		
04.0.1=	CLIMMADY CT	ATEMENT OF DEFICIENCIES			DNI .	2/5
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
R 148	Continued From page	e 16	R 148			
	The door was left open and unattended for approximately 7 minutes.  Further interview with the Director of Health Services indicated when the door is opened the nurses "pager" would alert them that the door was opened.					
	Aide #5 were in the k	se #4 and Certified Nurses itchen area of the dining door was not visible when rea.				
	During observation from 12:35 p.m., an audible alarm could be heard on the nurses pager system. The nursing staff remained in the dining area and did not check the security of the entrance door.					
	Director of Health Selproblems with the nur alert as prompted on in a resident room an to check and see how nurses to answer the so I confronted the nu	2-28-14 at 1:20 p.m., the rvices indicated she had rsing staff not answering the the pager. "One day I stood d pushed the call button just v long it would take for the pager alarm. No one came urses about no response to prised about this situation."				
	p.m., titled "Accident Definition and Risk As shall provide adequat devices to prevent ac attempts. The facility	/ policy on 02-28-14 at 2:00 Prevention - Elopement ssessment," The facility te supervision and assistive cidents related to elopement is secured by key pad only. The resident's should ent."				
	A review of the facility "Morning side of Colle	/ "Mission Statement" for the ege Park Reflections				

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	IATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE S COMPL		
			A. BOILDING.		С		
	013034		B. WING		1	03/06/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
MORNING	SIDE OF COLLEGE PAR	8810 COLE					
	OLIMANA DV OT		OLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
R 148	Continued From page	e 17	R 148				
	indicated the following "At Reflections our mededicated to providing from Alzheimer's or recare and support they meaningful a left as p providing a safe envir "Environmental Desig of the Memory Support encourage and support promoting safety. Out the capabilities and w dementia as describe Security Features: El	emory care community is gour residents who suffer elated dementia with the related to them as ossible. We do this by conment "  In - the physical environment art Care unit is designed to cort independence while ar design features support rell-being of persons with delow: Safety and electronically-controlled anisms on exit doorways dareas."					
R 154	410 IAC 16.2-5-1.5(k) Standards - Deficience	Sanitation and Safety y	R 154			4/5/14	
	areas, common dining utensils clean, free from	eep all kitchens, kitchen g areas, equipment, and om litter and rubbish, and epair in accordance with 410					
	review the facility faile	t as evidenced by:  a, interview and record  at to ensure the kitchen was  in good repair for 1 of 1					
	Findings include:						

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	IED
		013034	B. WING		C	N0044
					03/00	5/2014
NAME OF P				TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	K 8810 COLI	BY BLVD OLIS, IN 46268	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
R 154	Continued From page	e 18	R 154			
	During observation or the Chef in attendance observed:	n 02-27-14 at 1:15 p.m., with e the following was				
	what was identified as the "Chef" was placed can.	chen double doors a rack of s "clean dessert dishes" by d directly next to the garbage e 'clean' dessert dishes e garbage.				
	had a red plastic buck The "Chef" indicated with a "quat" (a sanitized requested, the solution appropriate amount on "Chef" tested the solutesting strip indicated solution in the water.	_				
	and fresh food debris flooring and wall joine preparation areas, ste Vulcan oven and past In addition many of th grease like appearant food debris was obse surface. The dried/gr	try preparation area.  The areas appeared to have a concept the street the st				
	areas too numerous t cracked or broken. D at 2:15 p.m., the Exec	ughout the kitchen had o count which were chipped, ouring interview on 02-28-14 cutive Director indicated the did not have a membrane				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
		013034	B. WING		C 03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	8810 COL	BY BLVD POLIS, IN 46268	3		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
R 154	Continued From page	e 19	R 154			
	beneath the tiled surface, thus preventing the dietary staff from power washing the tiled floor.  Observation of the "dessert refrigerator" dried food debris was observed along the side of the metal racks and the bottom surface of the refrigerator. The Chef indicated the dessert refrigerator "could use a good cleaning."  A device identified by the "Chef" as a waffle iron, had an abundance of dried burnt on food beneath the metal surface on which the waffle iron had been placed.  The Vulcan oven, which had an upper and lower unit had an abundance of burnt on brownish/black substance throughout.					
	large plastic bins/conindicated the contents included bread crumb powdered sugar and was a plastic scoop p contents of the bin.	s in the bins/containers os, rice, corn meal, sugar, flour. Within each container blaced into each of the During observation the ice ed a scoop. The scoop was				
		ad a heavy build up of black along and around all 4				
	The air vent located in "mechanical room" has gray substance.	n the wall above the ad a heavy build up of dark				
	doors of the kitchen la	of the wall near the double acked plaster and a metal The areas had sections of				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		013034	B. WING		C 03/06/2014	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	MORNINGSIDE OF COLLEGE PARK  8810 COL INDIANA					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
R 154	Continued From page	20	R 154			
	During an additional of 12:00 p.m., the follow The rack of dessert diadjacent to the garbay. The dietary staff was both hands and remothe refrigerator. With identified the contents this observation the dietary staff memored the lid and pheen placed into and salad. The scoop was wrap. The staff memore wrap and placed the surface. The staff memore of tuna salad, placed and then re-wrapped plastic wrap and placed tuna salad mixture. The staff memore wrap and placed and then re-wrapped plastic wrap and placed and then re-wrapped plastic wrap and placed tuna salad mixture. The staff memore wrap and placed and then re-wrapped plastic wrap and placed and then re-wrapped plastic wrap and placed tuna salad mixture. The staff memore wrap and placed and the refrigeration was also believed to the staff weekly waffle iron and washalline after every shift,"	observation on 02-28-14 at ing was observed: ishes was observed ge can.  observed with gloves on observed with gloves on oved a plastic container from on this container, the cook is as "tuna salad." During iterary staff member, bicked up a scoop which had on top of the prepared tuna is wrapped in a clear plastic obser removed the plastic obser removed the plastic obser removed the counter of the scoop in the same of the scoop in the same of the scoop back into the observation of the counter of the staff member placed the tainer and placed the observation of the cleaning Checklist" on indicated the "Convection of the counter underneath it.," Grill "Refrigeration Units - line				
	Standards for Food C surfaces," indicated the	tion and Safety: Cleaning ontact and non-food contact ne following:				

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AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		013034	B. WING		C <b>03/06/2014</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE. ZIP CODE		
	SSIDE OF COLLEGE PAR	8810 CO	BY BLVD			
		INDIANA	POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
R 154	Continued From page	21	R 154			
	Wash all surfaces food with manual dish water.     Counternary Sanitary Sconcentration recomn	nended by the loors: 1. Sweep up all off floors."				
R 187	(k) Hot water temperal hand washing facilitie automatic control valve point of use must be inhundred (100) degree hundred twenty (120). This RULE is not mere Based on observation failed to ensure proper handwashing facility, temperature at the definithe kitchen, the territhan one hundred and for 1 of 1 handwashing. Findings include:  During a kitchen observation one hundred and for 1 of 1 handwashing. The handwashing sink see the kitchen area. The handwashing sink see	degrees Fahrenheit.  t as evidenced by: and interview, the facility or hot water temperatures for	R 187		4/5/14	

Indiana State Department of Health

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MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
		7 50.25		C	
	013034	B. WING		03/06/2014	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SIDE OF COLLEGE PAR	K		3		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
Continued From page	: 22	R 187			
with his dial thermome observation, the need right, and when the need the cook moved the the stream of water and p thermometer into the sink.  A subsequent request Maintenance Supervise	eter. During this lle continued to move to the eedle passed 130 degrees, nermometer from the blaced the tip of the water which remained in the t was made for the sor to check for the hot				
Maintenance Supervistemperature measure (Fahrenheit) and he in place an anti-scald de	sor indicated the water d at 140 degrees adicated he would "need to evice on it."				
410 IAC 16.2-5-4(e)(1	) Health Services - Offense	R 241		4/5/14	
provision of residential ordered by the reside supervised by a licens or on call as follows:  (1) Medication shall be nursing personnel or or this RULE is not mere Based on on observarieview the facility failed were given as prescri reviewed during medical supervised by the residential ordered in the residential orde	al nursing care shall be as int's physician and shall be sed nurse on the premises in administered by licensed qualified medication aides. It as evidenced by:  It as evidenced b				
	ROVIDER OR SUPPLIER  SSIDE OF COLLEGE PAR  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LE  Continued From page and Cook #9 took the with his dial thermome observation, the need right, and when the need right, and when the need right, and when the need the cook moved the the stream of water and pe thermometer into the sink.  A subsequent request Maintenance Supervise water temperature at  During interview on 00 Maintenance Supervise temperature measure (Fahrenheit) and he in place an anti-scald de  This State finding relat IN00145149.  410 IAC 16.2-5-4(e)(1)  (e) The administration provision of residential ordered by the reside supervised by a licens or on call as follows: (1) Medication shall b nursing personnel or of This RULE is not me Based on on observar review the facility faile were given as prescri reviewed during medi	DENTIFICATION NUMBER:  013034  ROVIDER OR SUPPLIER  SSIDE OF COLLEGE PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22  and Cook #9 took the temperature of the water with his dial thermometer. During this observation, the needle continued to move to the right, and when the needle passed 130 degrees, the cook moved the thermometer from the stream of water and placed the tip of the thermometer into the water which remained in the sink.  A subsequent request was made for the Maintenance Supervisor to check for the hot water temperature at this handwashing sink.  During interview on 02-28-14 at 12:30 p.m., the Maintenance Supervisor indicated the water temperature measured at 140 degrees (Fahrenheit) and he indicated he would "need to place an anti-scald device on it."  This State finding relates to Complaint IN00145149.  410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises	ROVIDER OR SUPPLIER  SIDE OF COLLEGE PARK  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22  and Cook #9 took the temperature of the water with his dial thermometer. During this observation, the needle continued to move to the right, and when the needle passed 130 degrees, the cook moved the thermometer from the stream of water and placed the tip of the thermometer into the water which remained in the sink.  A subsequent request was made for the Maintenance Supervisor to check for the hot water temperature at this handwashing sink.  During interview on 02-28-14 at 12:30 p.m., the Maintenance Supervisor indicated the water temperature measured at 140 degrees (Fahrenheit) and he indicated he would "need to place an anti-scald device on it."  This State finding relates to Complaint IN00145149.  410 IAC 16.2-5-4(e)(1) Health Services - Offense  (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.  This RULE is not met as evidenced by: Based on on observation, interview and record review the facility failed to ensure medications were given as prescribed for for 2 of 4 residents reviewed during medication pass, in a sample of	ROWDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SIDE OF COLLEGE PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 22  and Cook #9 took the temperature of the water with his dial thermometer. During this observation, the needle passed 130 degrees, the cook moved the thermometer from the stream of water and placed the tip of the thermometer into the water which remained in the sink.  A subsequent request was made for the Maintenance Supervisor to check for the hot water temperature at this handwashing sink.  During interview on 02-28-14 at 12:30 p.m., the Maintenance Supervisor indicated the water temperature measured at 140 degrees (Fahrenheit) and he indicated he would "need to place an anti-scald device on it."  This State finding relates to Complaint IN00145149.  410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows:  (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.  This RULE is not met as evidenced by: Based on on observation, interview and record review the facility failed to ensure medications were given as prescribed for for 2 of 4 residents reviewed during medication pass, in a sample of	

Indiana State Department of Health

STATE FORM 6899 GYZ711 If continuation sheet 23 of 37

NAME OF PROVIDER OR SUPPLIER  MORNINGSIDE OF COLLEGE PARK  MORNINGSIDE OF COLLEGE PARK  MINIMAPPOLIS, IN MASSES  MONAMAPPOLIS, IN MASSES  MONAMAPPORT AND A MASSES  MONAMAPPOLIS, IN MASSES  MONAMAPPORT AND A MASSES  MONAMA		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MARE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  810 COLBY BLVD  NDIANAPOLIS, IN 46288  PROVIDER'S PROVIDER'S PROCEDED BY FULL  REGULATORY OR ISC IDENTIFYING INFORMATION)  R 241  Continued From page 23  Findings include:  1. The record for Resident "E" was reviewed on 02-27-14 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hallucinations, depression, hypertension, arthritis and edema to the right leg related to deep vein thrombosis. These diagnoses rewards on administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse and placed a large bottle on the tops surface. The medication was labeled "Miralax 17 grams by mouth, place in 8 ounces of water." The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water. The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water. The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water. The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water and gave it to the resident.  2. The record for Resident "C" was reviewed on 02-27-14 at 12:00 pm. Diagnoses included, but were not limited to, Alzheimer's dementia, falls with injury, fecal syncope, seizures and hypertension. These diagnoses remained current at the time of the record review.  A review of the admission Physician orders, dated 02-22-14 instructed the nurse to administer			013034	B. WING			
MORNINGSIDE OF COLLEGE PARK   INDIANAPOLIS, IN 46268	NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00.00.2011	
R 241  R 241  R 241  Continued From page 23  Findings include:  1. The record for Resident "E" was reviewed on 0.2-27-14 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hallucinations, depression, hypertension, arthritis and edema to the right leg related to deep vein thrombosis. These diagnoses remained current at the time of the record review.  A review of the admission physician orders dated 02-26-14 instructed the nurse to administer Miralax (a laxative) 17 grams every day.  During the observation of medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medications for Resident "E".  The Licensed Nurse then reached in to the bottom drawer of the Medication cart, and then placed a large bottle on the top surface. The medication was ableed "Miralax -17 grams by mouth, place in 8 ounces of water." The Licensed Nurse and placed the contents in 4 ounces of water and gave it to the resident.  2. The record for Resident "C" was reviewed on 02-27-14 at 12-00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, falls with injury, fecal syncope, selzures and hypertension. These diagnoses remained current at the time of the admission Physician orders, dated 02-22-14 instructed the nurse to administer	MORNING	SIDE OF COLLEGE PAR	K		3		
Findings include:  1. The record for Resident "E" was reviewed on 02-27-14 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hallucinations, depression, hypertension, arthritis and edema to the right leg related to deep vein thrombosis. These diagnoses remained current at the time of the record review.  A review of the admission physician orders dated 02-26-14 instructed the nurse to administer Miralax (a laxative) 17 grams every day.  During the observation of medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medications for Resident "E."  The Licensed Nurse then reached in to the bottom drawer of the Medication cart, and then placed a large bottle on the top surface. The medication was labeled "Miralax - 17 grams by mouth, place in 8 ounces of water." The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water and gave it to the resident.  2. The record for Resident "C" was reviewed on 02-27-14 at 12:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, falls with injury, fecal syncope, seizures and hypertension. These diagnoses remained current at the time of the record review.  A review of the admission Physician orders, dated 02-22-14 instructed the nurse to administer	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE COMPL	ETE
i la companya da la c	R 241	Findings include:  1. The record for Res 02-27-14 at 11:00 a.m were not limited to, Al hallucinations, depres and edema to the right thrombosis. These di at the time of the record A review of the admis 02-26-14 instructed the Miralax (a laxative) 17 During the observation administration on 02-2 Nurse #4 prepared the "E."  The Licensed Nurse the bottom drawer of the placed a large bottle of medication was labeled mouth, place in 8 oun Licensed Nurse meas Miralax and placed the water and gave it to the control of the placed in the water and gave it to the control of the placed of the water and gave it to the control of the placed of the water and gave it to the control of th	sident "E" was reviewed on n. Diagnoses included, but zheimer's dementia, sion, hypertension, arthritis at leg related to deep vein agnoses remained current ord review.  sion physician orders dated ne nurse to administer grams every day.  n of medication 28-14 at 8:15 a.m., Licensed e medications for Resident  then reached in to the Medication cart, and then on the top surface. The ed "Miralax - 17 grams by ces of water." The sured the correct amount of e contents in 4 ounces of ne resident.  sident "C" was reviewed on n. Diagnoses included, but zheimer's dementia, falls ope, seizures and diagnoses remained current ord review.  sion Physician orders, dated ne nurse to administer	R 241			

Indiana State Department of Health

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		
		013034	B. WING		C 03/06/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	SSIDE OF COLLEGE PAR	RK 8810 COL INDIANAI	.BY BLVD POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
R 241	reached into the botto cart, and then placed surface. The medicaresident's name and label indicated the modirections to place "1 water." The Licensed correct amount of the contents in 4 ounces resident.  3. A review of the face 9:00 a.m., titled "Medication" and dated following:  "POLICY: The admires shall be as ordered be and shall be supervised the premises or on care the premises of the premises of the medication management following: C. Medical administered in accord dosage and frequency health services staff."  Review of a subsequency of the services of the premises of the premises."	Miralax. The Licensed Nurse om drawer of the Medication a large bottle on the top tion was labeled with the physician. In addition the edication was "Miralax" with 7 grams in 8 ounces of d Nurse measured the medication and placed the of water and gave it to the cility policy on 02-28-14 at ication Management 02/2013, indicated the mistration of medications y the resident's physician ed by a licensed nurse on all."  facility shall establish a ment system that ensures the ation are accurately redance with prescribed route, by by trained and authorized the ment policy on 02-28-24 at ication Management - ation," dated 02/2013,	R 241		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		С
		013034	B. WING		03/06/2014
	ROVIDER OR SUPPLIER	8810 COL	DDRESS, CITY, STA		
		INDIANAI	POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
R 241	Continued From page	25	R 241		
	given by mouth, appli or vaginal routes, or p	ed per nasal, eye, ear, rectal per metered dose inhaler will censed nurses or qualified			
R 273	410 IAC 16.2-5-5.1(f) Services - Deficiency	Food and Nutritional	R 273		4/5/14
		sidents ' units) are ance with state and local od handling standards,			
	staff was observed wi counter surfaces and	t as evidenced by:  and interview the dietary th gloved hands, touching food handling without ing during 1 of 1 lunch			
	Findings include:				
	p.m., the dietary staff were observed. The donned gloves and w certain food item, the pick up the item with gmembers were obserwhen a resident requidetary staff member with gloved hands picklettuce on the plate aronto the lettuce. The up the scoop and and the croissant. The staff were observed.	members at the steam table dietary staff members had hen a resident requested a dietary staff member would gloved hands. Multiple staff wed with gloves on, and ested a tuna croissant, the picked up a plate and then ked a lettuce, placed the had then placed a croissant staff member then picked a placed amount of tuna onto aff member then took pieces placed them around the			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		C
		013034	B. WING		03/06/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
MORNING	SIDE OF COLLEGE PAR	8810 COI	LBY BLVD		
		INDIANA	POLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
R 273	Continued From page	26	R 273		
	change gloves or use onto the resident's pla				
		ring was observed for 5 tions for the lunch meal.			
	"Chef" indicated the c washing their hands i and shouldn't be touc	n between changing gloves hing other items with gloves the resident's food. "It's like			
	This State finding rela IN00145149.	ates to Complaint			
R 301	410 IAC 16.2-5-6(c)(5 Deficiency	5) Pharmaceutical Services -	R 301		4/5/14
	the following:  (A) Resident 's full na  (B) Physician 's name (C) Prescription numb (D) Name and streng (E) Directions for use (F) Date of issue and applicable).	e.  per. th of the drug.  expiration date (when  as of the pharmacy that filled  aged in a unit dose, that comply with the			
		t as evidenced by: tion, interview and record ed to ensure the appropriate			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SUR COMPLETE		
		042024	B. WING		C	0044
		013034	B. WING		03/06/2	2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	2K	_BY BLVD POLIS, IN  46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
R 301	Continued From page	e 27	R 301			
		n medications for 1 of 4 uring medication pass, in a ent "E").				
	Findings include:					
	02-27-14 at 11:00 a.n were not limited to, Al hallucinations, depres and edema to the righthrombosis. These di at the time of the reco	ssion, hypertension, arthritis nt leg related to deep vein iagnoses remained current ord review.				
	the drawer of the medithe medication was some resident at 8:00 a.m indicated the medicate (milligrams). The bott	picked up a small bottle from dication cart and indicated cheduled to be given to the The label on the bottle cion was Aspirin 81 mg. le was not labeled with the ne, the physician's name, a or directions for use.				
	bottle and also indica scheduled for 8:00 a. indicated "Zantac [an	hen picked up another small ted the medication was m., The label on the bottle anti-ulcer medication] 150 day." The medication label dministration.				
	placed a large bottle of medication was labeled	then reached in to the Medication cart, and then on the top surface. The ed "Miralax [a laxative] - 17 the in 8 ounces of water."				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			,
		013034	B. WING		1	6/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	K 8810 COL		n		
240.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	POLIS, IN 46268	PROVIDER'S PLAN OF CORRECTION	ANI	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
R 301	1 Continued From page 28		R 301			
	During an interview o Director of Health Seinstructed a nurse of	d placed the contents in 4 gave it to the resident.  n 02-28-14 at 2:00 p.m., the				
	9:00 a.m., titled "Med	ity policy on 02-28-24 at ication Management - ation," dated 02/2013, g:				
	"POLICY: The Administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises."					
	given by mouth, appli or vaginal routes, or p be administered by lic medication aides in a physician's orders. 7 administered per staf per the resident must include the following: Physician's name, C. Name of strength of t	. Medications ordered to be for to be self-administered be properly labeled to A. Resident's full name, B. Prescription number, D. the drug, E. Directions for e and expiration date [when e and address of the				
R 354	410 IAC 16.2-5-8.1(g Noncompliance	)(1-7) Clinical Records -	R 354			4/5/14
	(g) A transfer form sh	all include the following:				

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		013034	B. WING		03/06/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
		8810 COL		,	
MORNING	SIDE OF COLLEGE PAR	RK INDIANAI	POLIS, IN 4626	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
R 354	Continued From page	= 29	R 354		
	<ul> <li>(1) Identification data</li> <li>(2) Name of the trans</li> <li>(3) Name of the receitransfer.</li> <li>(4) Resident's persotransferred to an acut</li> <li>(5) Nurses' notes re</li> </ul>	deferring institution.  If the ving institution and date of the ving institution and date of the ving institution and date of the ving institution and property when the care facility.  It is the ving institution and physical limitations;  If the ving institution is the ving institution and physical limitations;  If the ving institution is the ving institution in the ving in the ving in v			
	This RULE is not met as evidenced by: Based on record review and interview the facility failed to ensure a complete transfer form, in that when a resident was sent to a local area hospital for behaviors, the transfer form lacked sufficient information related to the resident's condition/behaviors which prompted the transfer for 1 of 5 sampled residents. (Resident "A")				
	Findings include:				
	02-27-14 at 10:15 a.n were not limited to, Le	ent "A" was reviewed on n. Diagnoses included, but ewy Body dementia and nese diagnoses remained the record review.			
		nitted to the facility on I at a secured dementia unit I to the facility.			
	A review of the 24 ho following related to R	ur Report book noted the esident "A."			

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PRINTED: 04/17/2014 FORM APPROVED

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MANE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  810 COLEY BLVD  NIDIANAPOLIS, IN 48288    D		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADRESS, CITY, STATE, ZIP CODE  8101 COLBY BLVD  NDIANAPOLIS, IN 46288  810 COLBY BLVD  NDIANAPOLIS, IN 46288  PROVIDERS PLAN OF CORRECTION  (EACH DECIDION WIJST BE PRECEDED BY FULL  REQUIATORY OR LSC IDENTIFYING INFORMATION)  R 354  Continued From page 30  "02.11-14, 3:00 to 11:00 p.m., - slightly agitated most of shift. 02-19-14, 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14, 7:00 a.m., to 3:00 p.m., agits people are in his room. 02-21-14, 7:00 a.m., to 1:00 p.m., 30 minute checks - calm. 02-22-14, 7:00 a.m., to 1:00 p.m., agits size behavior during the day. 3:00 p.m., agoressive behavior during the day. 3:00 p.m., agoressive behavior during the day. 3:00 p.m. agoressive behavior during the following:  "02-21-14 at 10-10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into the vas sillo running his walker into the was also running his walker into the solic resident of the DON. Writer and DON attempted to take res. into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych hospital for evaluation. POA [power of attorney) notified and refused to have the res. [resident] sent out anythere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. agologized to writer and stated, I am				_			
MORNINGSIDE OF COLLEGE PARK    (A4)   D			013034	B. WING			
(X4)   D   SUMMARY STATEMENT OF DEPICIENCIES   D   PROVIDER'S PLAN OF CORRECTION   CACH DEPICIENCY MUST SE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   TROUBLE PROPRIATE   COMPLETE DIATE    R 354   Continued From page 30   R 354   R 354	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   TABLE   TO DEFICIENCES   TABLE   TO DEFICIENCY MUST BE PRECEDED BY FILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TABLE   TABLE	MORNING	SIDE OF COLLEGE PAR	K .		_		
REPER TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  R 354  Continued From page 30  "02-11-14 3:00 to 11:00 p.m., - slightly agitated most of shift. 02-19-14 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14 7:00 a.m., to 3:00 p.m., to 11:00 p.m., 30 minute checks - calm. 02-22-14 7:00 a.m., to 3:00 p.m., belt around neck."  A review of the Nursing Progress Notes indicated the following: "02-21-14 a 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the DON. Writer and DON attempled to take res. into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych hospital for evaluation. POA [power of attorney] notified and refused to have the res. [resident] sent out anywhere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. applogized to writer and stated, 1 am		I	INDIANAP	OLIS, IN 46268	8		_
"02-11-14 3:00 to 11:00 p.m., - slightly agitated most of shift. 02-19-14 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14 7:00 a.m., to 3:00 p.m., had episode of aggression. 3:00 p.m., to 11:00 p.m., 30 minute checks - calm. 02-22-14 7:00 a.m., to 3:00 p.m., aggressive behavior during the day. 3:00 p.m., to 11:00 p.m., belt around neck."  A review of the Nursing Progress Notes indicated the following: "02-21-14 at 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the bON. Writer and DON attempted to take res. into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych hospital for evaluation. POA [power of attorney] notified and refused to have the res. [resident] sent out anywhere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. apologized to writer and stated, 'l am	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	E
most of shift. 02-19-14 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14 7:00 a.m., to 3:00 p.m., had episode of aggression. 3:00 p.m., to 11:00 p.m., 30 minute checks - calm. 02-22-14 7:00 a.m., to 3:00 p.m., aggressive behavior during the day. 3:00 p.m., to 11:00 p.m., belt around neck."  A review of the Nursing Progress Notes indicated the following: "02-21-14 at 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the DON. Writer and DON attempted to take res. Into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych hospital for evaluation. POA [power of attorney] notified and refused to have the res. [resident] sent out anywhere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. apologized to writer and stated, 'I am	R 354	Continued From page	2 30	R 354			
notified and stated that next time if this res. becomes agitated and attacks staff, to send res. to [name of hospital] Emergency."  "02-22-14 at 9:00 a.m. Resident agitated at		"02-11-14 3:00 to 11:0 most of shift. 02-19-1 nervous and scared. room. 02-21-14 7:00 episode of aggressior 30 minute checks - ca 3:00 p.m., aggressior 3:00 p.m., to 11:00 p.  A review of the Nursing the following: "02-21-14 at 10:10 a. walker in the dining roup from his walker. The next to the resident at from falling from his walker into the into everything on this his walker into this walker into the into everything on this his walker into this walker into the into everything on this his walker into this walker into the unit. Res. was was also running his was also running his was also running his walker. In the into everything on this walker into the into everything on this his walker into the into everything on this walker into the into everything on this walker into the into everything on this walker. The into everything on this walker into the into everything on this walker. The into everything on this walker into the into everything on this walker. The into everything on this walker into the into everything on this walker. In the following:  [Into everything on this walker. In the into everything on this walker. In the into everything on this walker. In the following:  [Into everything on this walker. In the into everything on this walker. In the into everything on the into eve	200 p.m., - slightly agitated 14 3:00 to 11:00 p.m., Thinks people are in his 0 a.m., to 3:00 p.m., had 1. 3:00 p.m., to 11:00 p.m., alm. 02-22-14 7:00 a.m., to 12 behavior during the day. m., belt around neck."  Ing Progress Notes indicated 1. "Res. [resident] sat in his form and had refused to get this writer and the CNA set 1. The table to keep res. safe walker. Res. stood up and 1. The table to keep res. safe walker. Res. ran his walker 1. The DON 1. Was notified and had arrived 1. The DON 1. Writer 1. The tacking the staff. MD				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		013034	B. WING		C 03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SIDE OF COLLEGE PAR	8810 COL	BY BLVD			
MORNING	ODE OF GOLLEGE FAR	INDIANAP	OLIS, IN 46268	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
R 354	Continued From page	e 31	R 354			
	walker. Jabbed fork i several times. Becar	in the direction of nurse ne calm after rest period. de aware of behavior by				
	"02-22-14 at 8:25 p.m at 1400 [2:00 p.m.]. It 1440 [2:40 p.m.]. State how his day going <s 'tomorrow,="" [intramuscularly]="" [name="" [sibling]="" [which="" agai="" and="" around="" ativan.="" attempted="" being="" belt="" black="" box="" buried="" by="" checked="" coming="" cords,="" encouraging="" enough,'="" family="" had="" hands="" he="" held="" his="" hit="" holding="" i="" in="" incomple="" left="" mem="" member].="" minute]="" myself="" name]="" of="" on="" one="" paged="" phone,="" point.'="" regards="" remember]="" remove="" res.="" res.,="" sadministered="" she="" sigrabbing="" sitting="" stating="" talk.="" talking="" td="" the="" to="" tom="" tomorrow,="" tv="" tv<="" walking="" wanted="" when="" which=""><td>minded res. [name of family orrow, res. replied, ' Asked resident if he did state 'I'm, I'm not clear or talking. 6:40 p.m. saw his eyes open, and his neck medium tight. Began DON from room, and belt. DON quickly [under oved belt while restraining get Ativan [an anti-anxiety ic&gt; MD and request 9-1-1. ete sentences talking about ber], about res. older today states, 'there's no</td><td></td><td></td><td></td></s>	minded res. [name of family orrow, res. replied, ' Asked resident if he did state 'I'm, I'm not clear or talking. 6:40 p.m. saw his eyes open, and his neck medium tight. Began DON from room, and belt. DON quickly [under oved belt while restraining get Ativan [an anti-anxiety ic> MD and request 9-1-1. ete sentences talking about ber], about res. older today states, 'there's no				
	"02-22-14 at 10:40 p.	tip [towards head] of belt				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	6	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	` '	SURVEY PLETED
			A. BUILDING: _			
		013034	B. WING		03	C / <b>06/2014</b>
NAME OF PROVIDER OR SUPP	PLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNINGSIDE OF COLL	EGE DADI	8810 COL	BY BLVD			
WORKINGSIDE OF COLL	EGE PARI	INDIANAF	OLIS, IN 46268	3		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
R 354 Continued Fr	om page	32	R 354			
at 7:30 p.m. ( Administrator had went out events leadin Executive Dir well voice ma  "[Late entry] ( from [name o	Call place ] to notify to ER [e g up to the ector wa tills were  02-23-14 f adminis	at 6:25 p.m On 02-22-14 ed to [name of y him [name of resident] mergency room] and the his transfer. Also the s notified at this time as left with both parties."  at 6:28 p.m Return call estrator] he was informed of				
During an interest the Director of day of the ever rammed his work of the Director recovering from hit her with the indicated the and his foot the walker and "redementia unit 02-28-14 at 1 dementia unit pointed out the "rammed" the indented in a a metal corner lacked a pain was another a where the resemeasured 1 indicated shee "Wednesday 02-21-14 from she just want	erview or f Health ents on 0 valker intindicated om knee we walker resident rying to k ammed it. During 1:00 a.m. t were object walker. pproximal er protect ted surfalarea, as sident rarnch by 1 received or Thursin the nigled me to	ndition and transfer to ER."  n 02-27-14 at 11:00 a.m., Care indicated that on the 02-21-14, the resident to staff, including herself. I she was recently surgery when the resident The Director further was picking up the walker tick at staff and took the tinto the pillars" of the n an observation on the "pillars" on the pserved. Licensed Nurse #4 where the resident On one pillar was an area ately 1 inch by 2 inches and for was visible. The area fice. Adjacent to this pillar fidentified by the nurse, mmed the walker. This area finch. The Director further d a telephone call on a day" prior to the incident on the shift nurse. "She told me whow that she recognized of from his previous facility				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING		С	
		013034	B. WING		03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STAT	ΓE, ZIP CODE		
MORNING	SSIDE OF COLLEGE PAR	8810 COLE INDIANAP	OLIS, IN 46268	<b>.</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLI	ETE
R 354	Continued From page	e 33	R 354			
	Licensed Nurse #6 in the resident from the "concerned." "I told [i Health Services]." The that one day, at the powent to check on [nark had a knife. The CN/looked like maybe and the hall and he came throwing things out of could hurt you. The possible called."	name of the Director of the nurse went on to indicate revious facility, her aide the of resident "A"] and he the A tried to back away - and it army knife. "We ran down out swinging with it - he was if his room, heavy things that police department had to be				
	Director of Health Set the resident kept bandeverything. On the videolding onto the walk talking to [name of pheamily wouldn't let us that the doctor wante Friday - he tore up the [name of Resident "Document of Resident"] on the last set of the wouldn't get head of the w	2-28-14 at 1:00 p.m., the rvices indicated on 02-21-14 ging his walker into deo you can actually see me er with one hand and I was sysician] on the phone. The send him out to the hospital d him to go to, that was on e entire dining room. I heard "] start to come out of her NA to get her back in there urt. On Saturday was the That night he was pulling at just everything, he even d held set in the shower. It ere that we could get the s and around his wrists."  dent Transfer Form," dated he resident by name and the as transferring to, but lacked a resident was transferred addresses of all hospital cility from which Resident st 60 days, the address of a				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		013034	B. WING		C <b>03/06/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MORNING	SSIDE OF COLLEGE PAR	K	_BY BLVD POLIS, IN 46268	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
R 354	the relative or guardia transfer, lack of routin	ith telephone number and if in had been notified of the e and PRN (as needed) ertinent information" related dent needed to be	R 354		
R 414	hands after each direction hand washing is indiction professional practice.  This RULE is not mere Based on observation review the facility failed handwashing, in that dispensed medication licensed nurse failed after each direct resident observations and "D").  Findings include:  1. During an observation a.m., Licensed Nurse medications for Resident previously been in TV lounge. The licentic medication cart and president. Prior to preplicensed nurse had not the second professional president.	equire staff to wash their ct resident contact for which ated by accepted  It as evidenced by: It interview and record ed to ensure appropriate when a licensed nurse (#4) is to the residents, the ito perform handwashing ent contact for 4 of 4 It is (Residents "C", "E", "B"	R 414		4/5/14

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STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SUF COMPLET	
		013034	B. WING		C 03/06/	/2014
NAME OF PROVID	ER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
MORNINGSIDE	OF COLLEGE PAR	K 8810 COLE	SY BLVD DLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
The med the feet were med the staking Nurse initial. The Res med residence retuents the stook Nurse and The prep med walk seat residence residence in the seat residence in the	resident taking the se initialed the merord that the medical licensed nurse the dications for Reside prepared for the dications were admining area. Upong the prescribed se returned to the aled each medicated licensed nurse the dications into a pladent's room. The dent's room, instrumorning medication admining the prescribed medication were prescribed to the resident took the prescribed medications were prescribed to the resident took the prescribed medications were prescribed to the resident took the prescribed medications were prescribed to the resident took the prescribed on a sofa and dent she had the redent took the prescribed in the licens dent's room, amburecorded/initialed	sident. After completion of emedications, the licensed dication administration ations were administered.  en began preparation of ent "E." All mediations resident, and the ministered to the resident in a completion of the resident medications, the Licensed Medication Cart and ion as given to the resident.  en prepared medications for tensed Nurse placed the stic cup and proceed to the Licensed Nurse entered the acted the resident she had ons prepared, and the medications. The did the resident room, ation cart, and initialed in istration record the resident edications. The Licensed a bottle of hand sanitizer on on her hands.  then indicated she needed to ms for Resident "D." The pared, and the nurse "Is room. The resident was the nurse instructed the morning medications. Upon ed nurse exited the ulated to the medication cart	R 414			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		С
		013034			03/06/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  8810 COLBY BLVD					
MORNINGSIDE OF COLLEGE PARK INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
R 414	Continued From page 36		R 414		
	The nurse exited the and went to the TV lo hands after resident of the facility of the facility.	medication preparation area unge without washing her contact.  lity policy on 02-28-24 at ication Management - ation," dated 02/2013, gg:  nistration of medications y the resident's physician ed by a licensed nurse on  The licensed nurse and the aide will administer leting the following steps: A. Inly according to facility  lity policy on 02-28-14 at adwashing," and dated e following:			
	which handwashing is professional standard rub shall be available certain clinical situatio [Center for Disease C 2. Frequency of hand	n direct resident contact for is indicated by accepted is. An Alcohol-based hand for had decontamination in ons in accordance with CDC control] recommendations. It is divashing: C. Before and resident. G. After removing			

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